OFFICE OF THE INSPECTOR GENERAL

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QUARTERLY REPORT

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STATE OF CALIFORNIA

INTRODUCTION

his quarterly report summarizes the audit and investigation activities of the Office of the Inspector General for the period April 1, 2005 through June 30, 2005. The report satisfies the provisions of California Penal Code sections 6129, subdivision (c)(2) and 6131, subdivision (c), which require the Inspector General to publish a quarterly summary of completed investigations. To provide a more complete overview of the Inspector General's activities and findings, this report reaches beyond that requirement to also summarize audits and special reviews performed by the office during the quarter. All of the activities reported were carried out under California Penal Code section 6125 *et seq.*, which assigns the Office of the Inspector General responsibility for independent oversight of the California Department of Corrections and Rehabilitation (formerly the Youth and Adult Correctional Agency) and its subordinate entities: Adult Operations, Adult Programs, Juvenile Justice, the Corrections Standards Authority, the Board of Parole Hearings, the State Commission on Juvenile Justice, the Prison Industry Authority, and the Prison Industry Board.

BACKGROUND

The Office of the Inspector General investigates and audits the state's correctional departments, programs, and institutions to uncover criminal conduct, administrative wrongdoing, poor management practices, waste, fraud, and other abuses. The office conducts investigations, audits, and special reviews at the independent initiative of the Inspector General, as well as at the request of the Governor, members of the Legislature, and the Secretary of the Department of Corrections and Rehabilitation. The Office of the Inspector General also conducts an audit of each of the state's correctional institutions at least once every four years and performs a baseline audit of every warden one year after appointment. The Office of the Inspector General maintains a toll-free public telephone line to facilitate reporting of abuses in the Department of Corrections and Rehabilitation and the state's correctional institutions and investigates the complaints received.

During the second quarter of 2005, the office has continued re-building, restructuring, and re-staffing in response to new responsibilities assigned by the U.S. District Court and the Legislature for contemporaneous oversight of state prison internal affairs investigations. A Bureau of Independent Review has been established within the office to carry out those responsibilities, and the Bureau established three regional offices in Rancho Cordova, Bakersfield, and Rancho Cucamonga. The Inspector General's 2005-06 budget is \$15.4 million, with 96 funded positions, 43 of which will be filled this year.

The following pages summarize the audit and investigative activities of the Office of the Inspector General during the second quarter of 2005. A separate semi-annual report summarizing internal affairs investigations monitored by the Bureau of Independent Review, will be published in August 2005 and will be posted on the Inspector General's website at http://www.oig.ca.gov/.

SUMMARY OF INVESTIGATIONS

The Office of the Inspector General receives about 300 complaints a month pertaining to state correctional departments and institutions. Most of the complaints arrive by mail or through the Inspector General's 24-hour toll-free telephone line, while others are brought to the attention of the Office of the Inspector General in the course of audits or related investigations. The Office of the Inspector General may also conduct investigations at the request of agency or department officials in cases involving potential conflicts of interest by high-level administrators. The Inspector General's staff responds to each of the complaints and requests for investigation, with those involving urgent health and safety issues receiving priority. Most often the Inspector General's staff is able to resolve the complaints at a preliminary stage through informal inquiry or preliminary investigation by contacting the complainant and the institution or department involved and either establishing that the complaint is unwarranted or bringing about an informal remedy. Some of the complaints, however, warrant a full, official investigation.

During the second quarter of 2005, the Office of the Inspector General completed 12 full investigations. Following is a summary of those cases.

California State Prison, San Quentin. At the request of a civilian complainant, the Office of the Inspector General investigated a complaint stemming from an April 27, 2005 incident involving an administrator and a health care manager at California State Prison, San Quentin. In substance, the complaint alleged that during a meeting of top correctional officials the administrator promoted a "Code of Silence" by publicly accusing the health care manager of lying about the volume of patients being seen at the prison and by publicly suggesting that the health care manager's supervisors should discipline the manager for speaking privately with a court approved monitor (a Prison Law Office attorney) during a tour of the facility. The complaint also alleged that the administrator cancelled sick call clinics on April 6, and 7, 2005 over the objections of the health care manager and in violation of the settlement agreement in *Plata v. Schwarzenegger*, which is intended to ensure that medical care and treatment of inmates at California prisons meets minimum constitutional standards. According to the *Plata* settlement, the health care manager is responsible for the daily administration of all health care services at the institution.

Result: As a result of the investigation, the Office of the Inspector General found that the administrator's public accusation of untruthfulness on the part of the health care manager was unprofessional, discourteous and inappropriate for that setting. The Office of the Inspector General also found that the administrator's suggestion that the health care manager should be disciplined for speaking privately with the court approved monitor was inappropriate because it discouraged full compliance with the *Plata* settlement and advocated a violation of the department's "Code of Silence" policy. The Office of the Inspector General found in addition that a lack of cooperation between the custody and medical staff resulted in a temporary reduction of health care services at the prison.

Recommendations: The Office of the Inspector General recommended that the hiring authority take appropriate action against the administrator for failure of

good behavior and discourteous treatment of staff, for discouraging full compliance with the terms of the *Plata* settlement and for advocating a violation of the "Code of Silence" policy.

The Office of the Inspector General also recommended that the Department of Corrections continue its training at California State Prison, San Quentin and all other state prisons regarding the conditions of the *Plata* settlement. Specifically, the training should clarify that the custodial staff must cooperate with the medical staff and does not have the authority to make clinical decisions or to redirect the medical staff or suspend services absent an emergency. The Office of the Inspector General further recommended that the department consider instituting a policy requiring the authorization and signature of the appropriate medical authority for the significant reduction of medical services.

Status: The Office of the Inspector General referred the matter to the Director of the Department of Corrections for appropriate action. The administrator's appointment was subsequently rescinded.

N.A. Chaderjian Youth Correctional Facility. At the request of the California Youth Authority, the Office of the Inspector General investigated a complaint against a facility administrator following a fight involving 44 wards on the evening of May 27, 2005 at the N.A. Chaderjian Youth Correctional Facility. The complaint alleged that, following the disturbance, the administrator used unreasonable force on a ward involved in the fight. Specifically, as the ward was being escorted to another living unit by Youth Authority staff, the administrator allegedly grabbed the ward by the hair at the back of his head with one hand and grabbed him by the jaw with the other hand. The complaint also alleged that the administrator slammed the ward's head against a wall.

Result: As a result of the investigation, the Office of the Inspector General found that, although the ward was struggling against his escorts, the administrator used unreasonable force. The administrator admitted briefly grabbing the ward by the hair and jaw, explaining that he believed the use of force was reasonable because the ward posed a threat to staff. The California Youth Authority's use-of-force policy allows for the application of physical force when reasonably necessary to subdue an attacker, overcome resistance, effect custody, or to gain compliance with a lawful order. Here, the Office of the Inspector General found that although it may have been appropriate to utilize some force in assisting the other staff members, it was not reasonably necessary to pull the ward's hair and grab his face because the ward was handcuffed (behind his back) and he was under the physical control of escort officers. In addition, none of the other staff involved believed the ward was a threat to escape or harm staff.

With respect to the allegation that the administrator slammed the ward's head into a wall, apart from the ward there were no witnesses to the alleged act nor were there bruises or abrasions on the ward's head. Accordingly, there was insufficient evidence to sustain the allegation.

In addition, the Office of the Inspector General found that the administrator violated California Youth Authority policy governing the reporting and

documenting of the use of force. The applicable use-of-force policy requires all staff who use or witness force to report and document their observations. Further, employees who use force must document that fact in a written report prior to departing the facility. Although the administrator acknowledged he used force on the ward on May 27, 2005, he failed to file a written report prior to departing the facility. Moreover, he failed to document the actions of others or to require supervisory staff to ensure reports were submitted by participants and witnesses. The administrator filed his report the next day only after being alerted of the allegations against him. Despite receiving use-of-force training earlier that month, none of the staff who witnessed the May 27, 2005 incident or participated in the restraining of the ward filed a report according to policy. Such inaction violates the departmental policy on the Code of Silence in effect at the time of the incident. That policy states in part that "[F]ostering the Code of Silence includes the failure to act when there is an ethical and professional obligation to do so. Any employee...who fails to report violations of policy or who acts in a manner that fosters the Code of Silence, shall be subject to discipline up to and including termination."

Recommendations: The Office of the Inspector General recommended the hiring authority take appropriate action to address the administrator's use of unreasonable force against the ward on May 27, 2005. The Office of the Inspector General also recommended the hiring authority take appropriate action to address the administrator's failure to document the use of physical force on the ward and the administrator's violation of the Code of Silence.

Lastly, the Office of the Inspector General recommended the hiring authority take appropriate action against staff who failed to report their use of force or the use of force they observed being used against the ward.

Status: The Office of the Inspector General referred the matter to the Secretary of the California Department of Corrections and Rehabilitation on July 20, 2005 for appropriate action. The administrator has been notified that his Career Executive Appointment will be terminated on August 10, 2005.

Wasco State Prison-Reception Center. The Office of the Inspector General investigated a complaint that members of the correctional staff at the Wasco State Prison Reception Center used excessive force to remove an inmate from his cell while the inmate was under the influence of inmate-manufactured alcohol. The complaint alleged the staff did not follow approved policies and procedures in removing the inmate from the cell and in processing his complaint.

Result: The Office of the Inspector General found insufficient evidence to conclude the staff used force to remove the inmate from his cell, responded inappropriately to the incident, or failed to process the inmate's complaint in accordance with policies and procedures in effect at the time of the incident.

Recommendations: None.

Status: The case was closed and a closure letter was sent to the complainant.

California Medical Facility. The Office of the Inspector General conducted an inquiry into an allegation the staff at the institution had not responded to an inmate's appeal concerning his placement in administrative segregation. The complainant alleged that his administrative segregation placement had not been reviewed as required by regulations and that he had not been seen for nearly five months. The inmate said his placement in administrative segregation was not his fault and that he was concerned his approaching release date would be extended. The Office of the Inspector General conducted a site visit, reviewed institution records, and discussed the history of the inmate's appeals with institution staff.

Results: The investigation determined the inmate's administrative segregation placement had been initiated to protect the integrity of an investigation into alleged correctional officer misconduct. The Office of the Inspector General found that the institution had initiated an investigation into the inmate's allegations and that the investigation was still pending at the time of the site visit. According to institution records, the inmate had filed an appeal in which he requested that his half-time credits (for good behavior) be restored during his administrative segregation stay in order to maintain his release date. The appeal was partially granted at the second level, but it appeared that no changes had been made to the inmate's file. Based on a review of the inmate's central file and discussions with the classification and parole representative, the Office of the Inspector General determined that the inmate was overdue for an Institution Classification Committee review, which should address his concerns relating to his administrative segregation placement.

Recommendation: The Office of the Inspector General recommended to the institution staff that the inmate be scheduled for an Institution Classification Committee review.

Status: The inmate was scheduled for the Institution Classification Committee review. The committee reviewed the inmate's need for continued administrative segregation placement and clarified and corrected his work credit earning status. As a result, the inmate was released to parole on time. The Office of the Inspector General found no evidence that the situation resulted from systemic problems with the classification or appeals process and concluded that no further intervention was necessary. The case was therefore closed.

Substance Abuse Treatment Facility at Corcoran. The Office of the Inspector General investigated an allegation from a member of the institution staff that terminally ill inmates at the institution are not provided with proper medical care. The complainant alleged that inmates are returned to their cells to die without treatment instead of being transferred to the correctional treatment center and that the prison management does not comply with the mandates for treatment of inmates specified in the *Plata, Coleman*, and *Armstrong* court settlements.

The complainant further alleged that the institution engages in the "illegal" use of chemical agents to extract inmates from cells and that "CS" gas (ortho-chloro-benzal

malonitrile) is being used, even though the substance is to be used only in extreme emergencies. The complainant cited a rumor that on one occasion inmates being extracted were trying to "claw their way out of their cells," and he identified other instances in which chemical agents were used as punishment, rather than as protection.

Finally, the complainant alleged that he had been subjected to retaliation because of his opposition to the warden during the warden's legislative confirmation.

Results: The Office of the Inspector General found that the Office of Investigative Services of the Department of Corrections and Rehabilitation was already conducting an evaluation of the complainant's contention that he has been subjected to retaliation by the warden.

Recommendations: The Office of the Inspector General recommended that the Department of Corrections and Rehabilitation investigate the allegations concerning the lack of medical treatment for terminally ill patients and the use of CS gas to control inmates.

Status: The Office of the Inspector General referred the case to the Office of Investigative Services of the Department of Corrections and Rehabilitation.

Law Enforcement and Investigations Unit. The Office of the Inspector General reviewed allegations by some special agents of the Department of Corrections Law Enforcement and Investigations Unit of misconduct by Law Enforcement and Investigations Unit administrators and supervisors ranging from unprofessional and unethical behavior to harassment, battery, and misuse of state resources. The agents alleged that they were subjected to retaliation and reprisals from an administrator in that they were forced to relocate from their assigned area to Sacramento, which caused them financial loss. The Office of the Inspector General conducted an extensive review of the documentation submitted by the agents, as well as documentation obtained from the Office of Investigative Services, which had conducted a previous evaluation of the same allegations.

Results: The Office of the Inspector General determined that the Department of Corrections and Rehabilitation had appropriately addressed the allegations of misconduct and that the other allegations would be more appropriately addressed through the employee grievance process. The Office of the Inspector General found insufficient evidence to indicate that the department had acted inappropriately and concluded that no further intervention was necessary.

Recommendations: None.

Status: Case closed.

High Desert State Prison. The Office of the Inspector General reviewed documentation surrounding a May 26, 2004 incident in which an inmate alleged he was subjected to excessive use of force. The inmate alleged a correctional officer attacked him from behind without provocation while he was housed in a gymnasium and that he received a serious head injury that required brain surgery when his head apparently hit a locker during the altercation. The Office of the Inspector General reviewed the Category I

investigation conducted by the institution into the incident and interviewed the staff involved. The staff member in question reported during the Category I investigation that he was required to use force to subdue the inmate because he believed that his safety was in jeopardy after the inmate allegedly committed battery by walking into him. Based on evidence from a voice stress analysis demonstrating that the alleged victim was not truthful, the department investigator determined the allegations should not be sustained. Other inmate witnesses who provided testimony contrary to that of the alleged victim were found through voice stress analysis to be telling the truth. The investigator also noted that other inmate witnesses in the housing unit had been given a written description of the incident by the alleged victim's family, causing the testimony of those potential witnesses to be suspect.

Results: The Office of the Inspector General concluded that the investigation into the matter was conducted in an appropriate manner, the finding of "not sustained" appeared to be appropriate, and no further investigation by the Office of the Inspector General was warranted.

Recommendations: None.

Status. Case closed.

California State Prison, Solano. The Office of the Inspector General conducted a site visit and survey into the operating practices of the institution's inmate appeals process following an allegation that the institution's Inmate Appeals Office was improperly screening out appeals. The complainant alleged that his rights to appeal were violated when his appeal concerning an institution lockdown was screened out.

Results: A review of appeal reports and discussions with the appeals staff revealed a significant backlog of appeals at the first and second levels, with the backlogged appeals approximately one month beyond required due dates. The Office of the Inspector General was advised that the administration had ordered responses to some of the overdue appeals to be delegated to other facility staff to address the backlog. Although the appeal concerning the institution lockdown may have been improperly screened out, the Office of the Inspector General found the issue to be moot because the lockdown had been concluded and no further intervention was warranted.

As a result of the survey, the Office of the Inspector General is initiating a broader review of appeals offices at other institutions to identify any systemic issues concerning overdue appeals. The Department of Corrections and Rehabilitation's Inmate Appeals Branch has advised that later this month it will provide the Office of the Inspector General with monthly statistics for backlogged appeals by institution.

Recommendations: None.

Status: The case regarding the improperly screened appeal has been closed. A review of backlogged overdue appeals statewide is presently underway.

California State Prison, Corcoran: The Office of the Inspector General conducted an inquiry into an allegation that the institution medical staff continued to provide an inmate with a poorly fitting colostomy bag after an appropriately fitting bag was approved by the chief medical officer. The complainant claimed the poorly fitting bag leaks and causes skin irritation.

Results: Discussions with medical staff and a review of the inmate's medical records verified that the chief medical officer had approved the inmate's appeal for the proper colostomy bag, but that this particular bag was not in stock at the institution. According to the medical staff, the inmate has had multiple surgeries, which have caused scarring at the site, resulting in the problems he is experiencing. It would be difficult for any bag to fit perfectly, but modifications and adjustments could be made to remedy the situation. The inmate's medical records indicate he has been receiving ongoing treatment and evaluation by medical staff concerning this issue before and after this inquiry, and that the staff is actively seeking to attempt remedy the situation.

Recommendations: None.

Status: Case closed.

Mule Creek State Prison. The Office of the Inspector General investigated a complaint that Mule Creek State Prison failed to investigate staff misconduct outlined in a CDC-602 inmate appeal. The complaint involved a correctional officer who was alleged to have made inappropriate sexual comments and references to inmates.

Results: As a result of the investigation, the Office of the Inspector General found that employees in the appeals unit of Mule Creek State Prison had responded appropriately to the CDC-602. The Office of the Inspector General found that the inmate who filed the CDC-602 withdrew his appeal after being interviewed about the allegations and that the CDC-602 did not contain any of the allegations he later alleged in correspondence to other agencies. During the course of the investigation, the Office of the Inspector General discovered that the allegations against the correctional officer had been investigated.

Recommendations: None.

Status: Case closed

California State Prison, Sacramento. The Office of the Inspector General investigated a complaint that an inmate with severe mental health problems was being inappropriately housed at California State Prison, Sacramento. The complainant claimed the inmate should be housed in a Department of Mental Health facility where he could receive proper treatment for his mental condition. The complainant further reported that the inmate's mother was requesting his transfer to Atascadero State Hospital.

Results: The Office of the Inspector General determined that the inmate is receiving ten hours a week of group therapy and has regular contact with clinicians, psychiatrists, and mental health technicians. The inmate's assigned

mental health technicians stated in interviews that he is programming and participating in therapy sessions; that he is stable and is voluntarily taking his medications; that he has been responding well to treatment; and that his condition has improved. The clinicians said his condition was not of a nature that would requirement placement in a Department of Mental Health facility. The Office of the Inspector General determined that no further intervention is necessary.

Recommendations: None.

Status: Case closed.

California State Prison, Los Angeles County. The Office of the Inspector General investigated several complaints from an inmate and his mother that staff at California State Prison, Los Angeles County have falsely imprisoned him in administrative segregation, committed assault and battery on him, and stole his personal property. The inmate and his mother alleged that his rights have been continuously violated because the institution refuses to accept his appeals and impedes his legal mail. The inmate complained that he is subjected to abuse, mental anguish, lack of proper medical care, and numerous other issues.

Results: A review of the documentation submitted by the complainant and obtained from his files revealed that the inmate was placed in administrative segregation after the staff received confidential information that his safety was jeopardized by other sensitive-needs inmates. A review of the inmate's appeals history also revealed that the institution had accepted many of his appeals, but that many others had been appropriately rejected based upon his failure to comply with appeals regulations.

The Office of the Inspector General concluded that the institution's decision to retain the inmate in administrative segregation pending his transfer to another institution appeared to have been in the inmate's best interests and in compliance with department regulations. An extensive review of the issues raised by the complainant found insufficient evidence to support any of his other allegations, many of which were minor in nature. The inmate has since been transferred to another institution and many of the issues therefore have become moot. The Office of the Inspector General concluded that no further intervention is warranted.

Recommendations: None.

Status: Case closed.

Salinas Valley State Prison. The Office of the Inspector General investigated a complaint that Salinas Valley State Prison failed to investigate a complaint from an inmate that he and his fiancée were subjected to harassment and retaliation by the visiting room staff. The inmate also alleged that he was improperly placed in administrative segregation and did not receive medical care while he was in administrative segregation.

Results: As a result of the investigation, the Office of the Inspector General found that the inmate was appropriately placed in administrative segregation and that he

was provided with medical care in a timely manner. The allegation of staff misconduct in the visiting room is currently under investigation by the institution.

Recommendations: None.

Status: After the investigation into staff misconduct is completed, the results will be forwarded to the Office of the Inspector General for review.

SUMMARY OF AUDITS AND SPECIAL REVIEWS

The Office of the Inspector General completed one management review audit and two special reviews during the second quarter of 2005. The audit and special reviews are summarized below.

Management Review Audit of the N. A. Chaderjian Youth Correctional Facility. In May 2005, the Office of the Inspector General issued a management review audit, conducted between October 27, 2004 and April 29, 2005, of the N. A. Chaderjian Youth Correctional Facility. The purpose of the audit was to provide a baseline assessment of the facility's performance in carrying out essential functions and to provide recommendations for correcting deficiencies.

At the time of the audit, the facility, which was designated for wards who are generally older and more serious offenders than wards in most of the state's other juvenile institutions, held a population of 590 male wards. The audit determined that the institution was failing to provide wards with mandated education and other programs and was not providing a safe environment for either wards or staff. The audit found that wards were not receiving the counseling and mental health care required under state law in part because the youth correctional counselors, who are designated to provide most of the counseling had almost no time to counsel wards because they were busy with custody and security duties. The youth correctional counselors also have almost no training in counseling. The audit also determined that the institution was endangering wards by failing to consistently monitor those receiving psychotropic medications with baseline and follow-up laboratory tests and timely psychiatric evaluations.

The Office of the Inspector General found in addition that wards at the facility were receiving only 40 percent of their assigned education programming and that more than a third of scheduled classes were being cancelled, mainly because teachers routinely did not appear for class. Special education wards at the institution —who represented 38 percent of the students at the facility's high school at the time of the audit — also were not receiving all of the special education service time they were mandated to receive.

The audit further determined that the institution was not complying with numerous department-mandated security requirements and that the facility was plagued with structural and design defects that jeopardized the safety of both wards and employees. The Office of the Inspector General presented 56 specific recommendations to address the deficiencies identified in the audit. The full text of the audit report can be viewed by clicking on the following link to the Inspector General's website: N. A. Chaderjian Youth Correctional Facility, Management Review Audit (May 2005).

Special Review into the Shooting Death of Inmate Daniel Provencio on January 16, **2005** at Wasco State Prison. In June 2005, the Office of the Inspector General's Bureau of Independent Review completed a special review into the circumstances surrounding the January 16, 2005 shooting death of Inmate Daniel Provencio on January 16, 2005 at Wasco State Prison. Provencio was struck in the head by a 40mm direct-impact "sponge" projectile fired by a correctional officer after a fight broke out among inmates during an evening meal. The review determined that investigations by other correctional entities into the incident had been thorough, objective, and timely, and that the conclusions reached that the actions of the officer involved complied with department policy were supported by the weight of the evidence. The review also identified a number of deficiencies that might have contributed to the incident, including inadequate training for employees in the use of direct-impact weapons and the failure of the institution staff to perform thorough security checks of the housing unit. The Office of the Inspector General also found emergency notification procedures for use-of-force incidents at Wasco State Prison to be deficient and noted that some of the evidence in the case may have been improperly handled, although that deficiency did not affect the investigation. The full text of the special review can be viewed by clicking on the following link to the Inspector General's web page: Special Review into the Shooting of Inmate Daniel Provencio on January 16, 2005 at Wasco State Prison (June 2005).

Special Review of the Commission on Correctional Peace Officer Standards and **Training.** In May 2005, the Office of the Inspector General completed a special review of the Commission on Correctional Peace Officer Standards and Training, known informally as C-POST. The purpose of the review was to assess whether the commission was fulfilling its mission of enhancing the training and professionalism of state correctional peace officers by developing and monitoring training and selection standards. The review determined that since its inception in 1998, the commission had made only minimal progress in developing correctional peace officer training standards. The review found that the commission had developed training standards for only seven of the 27 correctional peace officer classifications for which it was responsible and that it had yet to approve any of the standards that had been developed. The review also found that the commission's correctional peace officer apprenticeship program lacked components essential to an apprenticeship program and was threatened with decertification for non-compliance with state and federal standards. Under the Governor's reorganization plan, which was approved by the Legislature effective July 1, 2005, the Commission on Correctional Peace Officer Standards and Training was abolished and its responsibilities were transferred to the new Corrections Standards Authority within the Department of Corrections and Rehabilitation. Recommendations presented by the Inspector General as a result of the special review are nonetheless applicable to the new entity. The full text of the special review can be viewed by clicking on the following link to the Inspector General's web page: Commission on Correctional Peace Officer Standards and Training, Special Review, May 2005.